Planned Parenthood®
of Illinois

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Comments on Key Issues of the Affordable Care Act
Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois
The Health Care Reform Implementation Council
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INTRODUCTION

Planned Parenthood of Illinois (PPIL) is a member of the Campaign for Better Health Care and signs on in support of the comments on the Insurance Exchange submitted by them. That being said, PPIL has certain concerns related to reproductive health care which we must submit separately in order to add emphasis to their importance.

PPIL is a statewide health care organization which operates 17 health centers in Illinois. In FY 2009, PPIL provided 181,955 patient visits. We performed 22,882 Pap smears, 40,710 tests for sexually transmitted infections (STI's), and 18,667 pregnancy tests. We dispensed 228,714 birth control prescriptions. Over 60% of PPIL patients live at or below the federal poverty level. Approximately 55% of PPIL patients are eligible for the support of a government health program such as Title X Family Planning, Medicaid, or Illinois Healthy Women. Only 12.5% of our patients are covered by a health insurance plan.

PPIL is excited for the opportunities health care reform will bring for our patients in the coming years. We realize that we will likely be serving not only an influx of newly eligible Medicaid patients, but that we will also see a dramatic increase in the number of our patients who will be covered by an insurance plan because of the establishment of the Health Insurance Exchange (HIE) in 2014. Therefore, it is critical that the HIE be a strong entity that protects the interests of women and men in need of reproductive health care services.

One of the greatest concerns that the public had when the Affordable Care Act was debated was the fear of the loss of access to health care that people already had in their current health plan. The development of an Illinois Health Insurance Exchange is an opportunity to fulfill the promise that people will not lose the health care they already have. This means that the HIE must protect the progress that has already been made in access to reproductive health care, including access to contraception and abortion care, in Illinois and build upon it.

I. Functions of a Health Benefit Exchange

1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

- An Illinois HIE can be tailored to the specific needs of the Illinois health insurance market and the needs of Illinois residents. Illinois can design a strong HIE that will

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promote competition, avoid adverse selection, encourage participation, provide disclosure, ensure efficiency, and exercise regulatory authority over participating plans.

- Illinois should not settle for the minimum requirements set forth in the federal Affordable Care Act. Reproductive health care, and in particular women's health care, has historically been marginalized by the insurance industry. Illinois has a record of ensuring reproductive health care access in private health insurance through requirements in the Insurance Code. The reproductive health care provisions in the Illinois Insurance Code were enacted because real need has been shown after years of denials by insurance companies. An Illinois HIE can ensure that these protections will continue.

- For it to be beneficial to our patients, the HIE must require that plans include access to a wide range of reproductive health care services. The Affordable Care Act does require certain coverage and federal rules will be forthcoming. However, in many cases Illinois holds reproductive health care to a higher standard. Therefore, all plans should include coverage that is currently required to be covered by Medicaid and/or the Insurance Code:
    - All FDA approved methods of prescription contraceptive drugs and devices including the required exam and procedure. Because this is a preventive service, there should be no cost to the insured.
    - PAP smear test. Because this is a preventive service, there should be no cost to the insured.
    - Tests and treatment for sexually transmitted diseases.
    - Tests for HIV.
    - Clinical examination of the breast at least once every three years for women age 20 to 39 and annually for women age 40 and older. Because this is a preventive service, there should be no cost to the insured.
    - Mammograms (and ultrasound screenings as medically necessary) for all women age 35 and older: Women age 35 to 39 – one baseline mammogram; Women age 40 or older – one mammogram annually; For women under age 40 who have a family history of breast cancer or other risk factors, coverage must include a mammogram at the age and intervals considered medically necessary by the woman's health care provider. Because this is a preventive service, there should be no cost to the insured.
    - Fibrocystic breast condition.
    - Prosthetic devices or reconstructive surgery related to the mastectomy.
    - Physician determined length of hospital stay following a mastectomy.
    - Removal of breast implants if: the implants were not inserted for purely cosmetic reasons; and it is medically necessary for the breast implants to be removed.
    - Medically necessary pain medication and pain therapy related to the treatment of breast cancer.
    - Human papillomavirus vaccine. Because this is a preventive service, there should be no cost to the insured.
    - Maternity care, including prenatal and post-natal care and care for complications of pregnancy and care with respect to a newborn.
    - Prenatal HIV testing ordered by an attending practitioner.

- Minimum of 48 hours inpatient hospital stay following a vaginal delivery and 96 hours following a caesarian section for both mother and newborn.
- Abortion care.
- Medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.
- Surveillance tests for ovarian cancer for patients who are at risk for ovarian cancer.
- Annual digital rectal examination and a prostate specific antigen test for male insureds upon recommendation of a physician for asymptomatic men age 50 and over, African American men age 40 and over, men age 40 and over with family history.

- In addition, all plans must include these prohibitions:
  - Denial of coverage solely because the individual is the subject of abuse, has sought treatment for abuse, or has sought protection or shelter from abuse.
  - Use of genetic testing information to deny health coverage.
  - Charges for deductibles and co-payments for covered members who are victims of sexual assault or abuse.
  - Lifetime limits or exclusions on coverage for individuals with HIV/AIDS, breast, or reproductive tracts cancers.

- Also, all plans must allow female enrollees to designate a practitioner specializing in obstetrics, gynecology, or family practice as their Woman's Principal Health Care Provider (WPHCP). The WPHCP can provide services without a referral from the preferred provider organization.

- Finally, the Illinois HIE must ensure access to abortion care in health insurance. Federal guidance has been issued that outlines how a State can implement procedures to allow for coverage in subsidized plans without violating prohibitions on federal funds being used for abortion coverage. Currently, the majority of private health insurance covers abortion care. That coverage is usually consistent with coverage for surgical procedures, office visits, and prescription drugs. If the Illinois HIE ends up driving the Illinois insurance market and discourages or limits access to abortion care coverage, this will harm women. Often women do not anticipate a need for abortion coverage, but will expect such coverage when they need it. We cannot allow this medical care to be marginalized when it is currently part of the standard of coverage in insurance.

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

- The Illinois HIE must be more than simply an Internet portal used to shop for insurance coverage. The HIE is an opportunity to improve the insurance market in Illinois for those covered, employers, and even insurance companies. The Illinois HIE should be a place where those seeking coverage, both individuals and businesses, can find more choices, easy to understand information, and cost savings. Insurance companies should find the

HIE to be a facilitator of brining new customers into the market. It also should provide incentives for new insurance companies to provide coverage within the State.

- In order to accomplish these goals, again the HIE must be a strong entity that is designed to improve the insurance market in Illinois not just settle for the status quo. The development of the HIE should be forward thinking with tough provisions to protect consumers through transparency and disclosure on the part of insurance companies. It should consider structures to assist employers and ease their financial and bureaucratic burdens. And, it should make sure that there are a variety of insurance companies offering a variety of quality plans to Illinois consumers.

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

- The Illinois HIE should take on certain regulatory functions to ensure quality, accessibility, and affordability within the Illinois insurance market. First, only the highest quality plans should be allowed within the HIE. These plans should provide coverage for a wide range of reproductive health care including preventive and early detection services. By providing high quality coverage, these plans will have healthier enrollees and will save money in the long term. Second, the competition to be a plan included in the HIE should be value-driven not profit oriented. The HIE can take an active role in negotiating benefit packages and premiums to ensure that reproductive health services are not only covered but also affordable. Third, the plans should be required to provide consumers with clearly understandable information in order to give consumers the tools they need to purchase a plan that best meets their needs.

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

- An Exchange is not stronger if it permits any willing provider in. As stated above, only those providers of quality health insurance plans should be allowed into the Illinois HIE. If the HIE controls the quality of the plans it offers, it can drive up value overall and set the standard for the market in Illinois. The goal is not to become simply an ideal marketplace for insurance companies, but to be a marketplace that provides protection and benefits to consumers. Therefore, Illinois should use its authority to set specific standards, including those for reproductive health care coverage, and then allow all insurance companies the opportunity to bid to offer plans within the HIE.

II. Structure and Governance

1. If the Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

- At times insurance companies or conservative activists, have tried to limit access to reproductive health care through health insurance. Sometimes this has been politically motivated and sometimes it has been motivated by perceived financial concerns. In any event, the health and well being of the individuals should be the foremost concern. In order to avoid undue influence by any one interest - whether political, consumer, employer, or insurance industry – the Illinois HIE must be created as a separate independent agency. Governance of this entity can include certain stakeholders such as business and consumers, but should not include entities that have conflicts such as those selling insurance within the HIE. In addition, those governing the HIE should have relevant expertise in health care, insurance, and management.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

- In order to avoid control by any particular interest, any governing board should have certain "slots" assigned to represent the interests of those impacted by the HIE. For example, there should be an individual consumer representative, a business representative, etc. It is advisable to have multiple slots for each interest so that a variety of ideas and expert backgrounds can contribute. Again, insurers within the HIE should not have governance authority. However, their expertise is valuable, and there should be a mechanism in place to allow them to provide information and advice to the governing board. The members of a governing board should have staggered terms to ensure continuity and prevent sudden and drastic shifts in governance. There also should be a revolving door policy so that those serving on the governing board cannot move directly back and forth between the board and the insurance industry.

III. The External Market and Addressing Adverse Selection

1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

- The strongest method of eliminating adverse selection would be to eliminate the outside market and have the entire Illinois insurance market contained within the HIE. However, PPIL is keenly aware that not all Illinois residents will be allowed to purchase insurance coverage within the HIE. We must ensure that there is a safety net for those undocumented individuals who need access to quality health care. If the outside market cannot be eliminated, it is essential that a fair and even playing field be created for plans inside and outside the HIE.

2. What other mechanisms to mitigate "adverse selection" (i.e. requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

- It is likely that for practical as well as political reasons the outside market will not be eliminated in Illinois. In that case, as mentioned above, the same rules must apply to plans within and outside of the HIE. The Affordable Care Act (ACA) requires that there must be a sufficient number of in-network providers which is extremely important for access to gynecological and obstetric care. ACA also requires the inclusion of essential community providers, such as PPIL, that serve low-income, medically underserved individuals. These rules must be applied to plans both inside and outside the HIE.

- In addition, outside insurers should be required to offer the same products that are offered inside the HIE and these products should all cover a wide range of reproductive health care.

- Adverse selection can also be addressed by eventually opening the HIE to larger groups so that grandfathered and traditional ERISA plans would have the option of participating. This would extend risk to a wider pool and also provide high quality standards to those covered in these larger groups. Many of the women in these larger groups do not currently have coverage for basic women's health care such as contraception. The ability to extend a richer benefit package to employees while reaping the cost benefits would appeal to large employers.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

- PPIL has not seen an effective hybrid model. If Illinois considers that path, it must ensure the protections stated in prior answers.

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

- As stated above, yes all rules must apply both inside and outside the HIE. Only with an even playing field can the State avoid adverse risk selection and ensure stable risk pools. In the case of reproductive health care, if the rules are not across the board, there is a risk of a two tiered insurance marketplace for women's health care coverage. We risk plans within the HIE offering high quality women's health coverage while plans outside the HIE will offer low cost plans with very limited women's health coverage or high cost plans with better women's health coverage. We have seen such attempts to create a two tier system with the proposal of legislation to allow so-called "Consumer Choice" benefit packages. These bills would have allowed insurers to eliminate most of the women's health coverage currently required in the Illinois Insurance Code and thus provide sub-standard coverage at a cheap rate. We cannot allow for such a large segment of the population to be treated this way.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

- PPIL agrees with the CBHC that enrollment periods may be specified and that changes in circumstances, such as birth or adoption of a child, should allow for special enrollment. In cases where documentation of citizenship is required, we encourage the State to allow for a reasonable enrollment period prior to the actual provision of documentation to allow individuals time to collect necessary paperwork. This is especially important for those who are in need of time sensitive health services such as family planning and prenatal care. Women who are denied reproductive health care services because of a lack of paperwork will be put at risk of unintended pregnancy or fetal/birth complications.

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

- See CBHC comments.

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

- See CBHC comments.

IV. Structure of the Exchange Marketplace

1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

- In order to develop the strongest and most efficient marketplace the Illinois HIE should be include both individuals and small groups. This will reduce administrative expenses and stabilize the risk pool.

2. If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both?

- See CBHC comments.

3. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

- Initially the State may need to limit the number to 50. However, if the goal is to ensure quality insurance coverage to as many individuals as possible, the size of a small business should be incrementally increased within a determined time period with the limit going to at least 100 by 2016.

4. Should Illinois consider setting any conditions for employer participation in the shop Exchange (e.g. minimum percent of employees participating, minimum employer contribution)?

- In order to avoid adverse selection and driving business outside of the HIE, the employer size standards should be the same within and outside the HIE. Illinois must consider that there are a number of types of employers and determine if eventually it would be beneficial to create standards that include larger numbers of employees. As stated previously, grandfathered employers and large employers often do not cover the same high quality reproductive health care that is required under the Illinois Insurance Code. Eventually including these employers in the HIE would benefit the employees who desire better coverage. It could also provide these employers with administrative and cost efficiencies.

5. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

- See Question #3. When including larger employers, adverse selection is a risk if only those large employers who have poor track records join the HIE. While we recognize that inclusion in the HIE is beneficial to employees, we cannot put the entire pool at risk. Therefore, the State must consider extending all regulations applied to the HIE to any employer whose group is eligible to participate in the HIE. This would mean that employees would reap benefits, but employers would not be given the incentive to "dump a high risk pool into the HIE.

6. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

- In order to ensure quality and competition, the State should not have multiple HIE's. Instead, the State should work to bring new companies into the market and provide incentives for providers, like PPIL, in underserved areas or serving at risk populations.

V. Self-Sustaining Financing for the Exchange

1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

- PPIL does not have a specific proposal for funding the HIE. However, any assessment on insurers should be applied to all insurers – those within and outside the HIE including self-funded plans.

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

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3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?

- Funding of benefits should be separated from the funding of the administration of the HIE. The specific benefit requirements have not been finalized by the federal government, however it should be noted that funding of preventive and early detection services reap savings. This is especially true in the areas of reproductive health care and family planning. This rationale should be considered when funding benefits.

VI. Eligibility Determination

1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

- Because most PPIL patients are eligible for government health programs and many of them regularly fall in and out of employment, we encourage the State to set up a coordinated system between Medicaid, CHIP, Illinois Healthy Women, any other program that provides reproductive health care services, and the HIE. This system should allow for one simple initial application that can be used no matter which program the individual is eligible for. Rules and verification requirement for government programs and HIE participation should be compatible. And, when a person's circumstances change, a seamless transfer of coverage should be implemented. If a consumer applies for a government program but is not eligible, eligibility for other programs and for HIE participation should be automatically determined and she should be immediately connected to the appropriate coverage mechanism. In turn, if the HIE discovers a person is eligible for a government program; she should be easily connected and enrolled. The electronic exchange of information should be facilitated between the HIE and State programs to ease this process.

- We anticipate that a large number of our patients who are already enrolled in programs such as Illinois Healthy Women and Title X Family Planning will be eligible for HIE participation with the assistance of subsidies. An outreach and education initiative should be undertaken to locate these individuals and provide them with the tools they need to take advantage of the opportunity for full health coverage. Many of our patients have no other health care provider because of lack of insurance. They rely on us because they can obtain subsidized services under certain programs. But, when we diagnose a problem that is outside of the scope of the program, they have nowhere to go for health care. Eligibility for the HIE will improve the overall health and well being of these patients.

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

- As stated previously, the State should examine and revise government program rules and systems to seamlessly interact with the HIE. The State should provide support for providers for the medically underserved. Many of these providers, like PPIL, are non-profit entities with limited resources. Streamlining bureaucracy and providing assistance

with adopting health information technology will ensure these providers remain stable and encourage them to expand services to more patients and communities.

3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

- Ensuring that each Medicaid recipient has access to a primary care provider is essential. Many of our patients need services we cannot provide but do not have access to a primary care provider. But, as the State moves Medicaid into greater coordination of care, it must still recognize the need to patients to choose their reproductive health care provider. The Medicaid and the Illinois Insurance Code already allow for choice in a women's health care provider.

- If the goal is to make sure women are empowered to take care of their reproductive health, we must give the option of choosing where they go and ensuring that barriers to access are eliminated. One of the most important factors in whether or not a woman will be successful in her efforts to plan her family is the effective use of contraception. Provider access and choice has a large influence on this. If a woman faces barriers accessing care and receiving contraceptive services, she may forgo using contraception, use it improperly, or use a less effective method, all of which put her at risk of unintended pregnancy. Therefore, she must have family planning providers available to her. In addition, because of the personal and intimate nature of family planning care, the patient must feel comfortable with the provider she sees. If a woman is uncomfortable with a provider or does not feel she can openly discuss sexual health issues with her provider, she is more likely to misuse or forgo use of contraception. Again, this puts her at risk of unintended pregnancy. Therefore, the State must continue to allow Medicaid enrollees to choose their family planning provider even if it means going outside of a preferred provider network or managed care plan.

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

- A Basic Health Plan could be a good option for people who move back and forth between Medicaid and the HIE. For it to be beneficial to our patients, the Basic Health Plan must include access to a wide range of reproductive health care services. The Affordable Care Act does require certain coverage and federal rules will be forthcoming. However, in many cases Illinois holds reproductive health care to a higher standard. Therefore the Basic Health Plan should include coverage that is currently required to be covered by Medicaid and/or the Insurance Code:
    - All FDA approved methods of prescription contraceptive drugs and devices including the required exam and procedure. Because this is a preventive service, there should be no cost to the insured.
    - PAP smear test. Because this is a preventive service, there should be no cost to the insured.

- Tests and treatment for sexually transmitted diseases.
- Tests for HIV.
- Clinical examination of the breast at least once every three years for women age 20 to 39 and annually for women age 40 and older. Because this is a preventive service, there should be no cost to the insured.
- Mammograms (and ultrasound screenings as medically necessary) for all women age 35 and older: Women age 35 to 39 – one baseline mammogram; Women age 40 or older – one mammogram annually; For women under age 40 who have a family history of breast cancer or other risk factors, coverage must include a mammogram at the age and intervals considered medically necessary by the woman's health care provider. Because this is a preventive service, there should be no cost to the insured.
- Fibrocystic breast condition.
- Prosthetic devices or reconstructive surgery related to the mastectomy.
- Physician determined length of hospital stay following a mastectomy.
- Removal of breast implants if: the implants were not inserted for purely cosmetic reasons; and it is medically necessary for the breast implants to be removed.
- Medically necessary pain medication and pain therapy related to the treatment of breast cancer.
- Human papillomavirus vaccine. Because this is a preventive service, there should be no cost to the insured.
- Maternity care, including prenatal and post-natal care and care for complications of pregnancy and care with respect to a newborn.
- Prenatal HIV testing ordered by an attending practitioner.
- Minimum of 48 hours inpatient hospital stay following a vaginal delivery and 96 hours following a caesarian section for both mother and newborn.
- Abortion care. Federal guidance has been issued that outlines how a State can implement procedures to allow for coverage in subsidized plans without violating prohibitions on federal funds being used for abortion coverage.
- Medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.
- Surveillance tests for ovarian cancer for patients who are at risk for ovarian cancer.
- Annual digital rectal examination and a prostate specific antigen test for male insureds upon recommendation of a physician for asymptomatic men age 50 and over, African American men age 40 and over, men age 40 and over with family history.

- In addition, the Basic Health Plan must include these prohibitions:
  - Denial of coverage solely because the individual is the subject of abuse, has sought treatment for abuse, or has sought protection or shelter from abuse.
  - Use of genetic testing information to deny health coverage.
  - Charges for deductibles and co-payments for covered members who are victims of sexual assault or abuse.
  - Lifetime limits or exclusions on coverage for individuals with HIV/AIDS, breast, or reproductive tracts cancers.

- Also, the Basic Health Plan must allow female enrollees to designate a practitioner specializing in obstetrics, gynecology, or family practice as their Woman's Principal Health Care Provider (WPHCP). The WPHCP can provide services without a referral from the preferred provider organization.

- Finally, we must make a special comment regarding abortion care. There must be a Basic Health Plan that offers coverage for abortion care. Currently more than half of private health insurance covers abortion care. In a similar fashion to coverage for surgical procedures, office visits, and prescription drugs. We cannot allow abortion care to be marginalized when it is currently part of the standard of coverage in insurance.

CONCLUSION

Planned Parenthood of Illinois hopes for positive changes that can come with the establishment of an Illinois HIE. Although we know that there will be many challenges in the coming years. We anticipate that there will be battles around the preservation of access to reproductive care that is already available under the Illinois Insurance Code. However, we believe that if the HIE is developed with the good health and well-being of Illinois residents as a top priority, it will benefit our patients who need access to reproductive health care. Therefore, we look forward to working with the Governor, the General Assembly and the Council in creating a strong HIE for Illinois.